ILLINOIS DEPARTMENT OF PUBLIC AID
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE:

- Federal law says that the Agency cannot share your Health Information without your permission except in certain situations. If you sign this form, you are giving the Illinois Department of Public Aid permission to share your Health Information the Illinois Department of Public Aid has with the person you indicate below.
- This Authorization is voluntary.
- **Right to Revoke:** If you decide you do not want the Illinois Department of Public Aid to share your Health Information any longer, sign the Revocation at the end of this form and give this form to the Illinois Department of Public Aid. If the Illinois Department of Public Aid has shared your Health Information for a research study, the Illinois Department of Public Aid may continue to use or share your Health Information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- The Illinois Department of Public Aid cannot promise that the person you permit the Illinois Department of Public Aid to share your Health Information with will not share your Health Information with someone else you may not want to have your Health Information.
- You can keep a copy of this Authorization, and can contact the Illinois Department of Public Aid Privacy Officer to get a copy if you do not have one.

My name: ..... Date of birth: .....
(print)

Social Security Number: .....

Recipient I.D. Number (RIN): .....

I give permission to: the **Illinois Department of Public Aid** to share my Health Information with:

.....

so that her/she/it may assist me with my health care issues.

The Illinois Department of Public Aid may share my Health Information for **one year** after the date on this Authorization form or until I revoke the Authorization

I want the Illinois Department of Public Aid to share this Health Information:
(check all boxes that apply):

- ❑ All of my Health Information
- ❑ Information regarding prescription drug coverage
- ❑ My Health Information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- ❑ My Health Information regarding treatment for alcohol and/or substance abuse
- ❑ My Health Information regarding behavioral health services or psychiatric care
- ❑ Other: .....

This form must be signed EITHER by the Recipient OR by the Personal Representative. The Recipient's parent may sign for the Recipient if the Recipient is a minor.

Signature of Recipient: ..... Date: .....

If this form is signed by the Personal Representative, please include a copy of the document naming the Personal Representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor

Signature of Personal Representative: ..... Date: .....

Relationship of Personal Representative: .....

REVOCATION OF AUTHORIZATION:

I no longer want the **Illinois Department of Public Aid** to share my Health Information with the person or entity indicated above.

My name: .....
(print)

Social Security Number: .....

Signature: ..... Date: .....

Send this **Authorization Form** or **Revocation of Authorization** to:

Privacy Officer
Illinois Department of Public Aid
P.O. Box 19159
Springfield, IL 62794-9159

Fax: 1-312-793-2005

Contact the Illinois Department of Public Aid Privacy Officer:

P.O. Box 19159
Springfield, IL 62794-9159
Toll-free telephone: 1-800-226-0768
(Health Benefits Hotline)

Toll-free for persons using a TTY: 1-877-204-1012
Fax: 1-312-793-2005
e-mail address: privacyofficer@mail.idpa.state.il.us